

14604631

Government Claim Form

Government Claims Program
California Victim Compensation and Government Claims Board
P.O. Box 3035
Sacramento, CA 95812-3035

1-800-955-0045 • www.governmentclaims.ca.gov

State of California
Government Claims Program

AUG 12 2016

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For Office Use Only
Claim No.:

FILING FEE RECEIVED
3328

Is your claim complete?

- ☒ Include a check or money order for \$25 payable to the State of California.
- ☒ Complete all sections relating to this claim and sign the form. Please print or type all information.
- ☒ Attach copies of any documentation that supports your claim. Please do not submit originals.

Claimant Information Use name of business or entity if claimant is not an individual

1	RICHARDS	RONALD	L	2	Tel:	
	Last name	First Name	MI	3	Email:	
4				PALM SPRINGS	CA	92262
	Mailing Address			City	State	Zip
5	Inmate or patient number, if applicable: _____					
6	Is the claimant under 18? NO If Yes, please give date of birth: _____					
7	_____					

If you are an insurance company claiming subrogation, please provide your insured's name in section 7.

8	_____
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If your claim relates to another claim or claimant, please provide the claim number or claimant's name in section 8.

Attorney or Representative Information

9	_____	10	Tel:	_____
	Last name	First Name	MI	
11	_____	11	Email:	_____
12	_____			
	Mailing Address	City	State	Zip
13	Relationship to claimant: _____			

Claim Information

14	Is your claim for a stale-dated warrant (uncashed check)? <input type="radio"/> Yes <input checked="" type="radio"/> No If No, skip to Step 15.			
	State agency that issued the warrant: _____			
	Dollar amount of warrant: _____		Date of issue: _____	
		MM	DD	YYYY
15	Date of Incident: 2-14-16			
	Was the incident more than six months ago? <input type="radio"/> Yes <input checked="" type="radio"/> No			
	If YES, did you attach a separate sheet with an explanation for the late filing? <input type="radio"/> Yes <input checked="" type="radio"/> No			
16	State agencies or employees against whom this claim is filed: FAE DAVID DELEON, CAL FIRE/RIVERSIDE COUNTY FIRE DEPT.			
17	Dollar amount of claim: \$374.82			
	If the amount is more than \$10,000, indicate the type of civil case:		<input type="radio"/> Limited civil case (\$25,000 or less) <input type="radio"/> Non-limited civil case (over \$25,000)	
	Explain how you calculated the amount: _____			

18	Location of the incident: DRIVEWAY GATE AT <div style="background-color: black; width: 200px; height: 1.2em; display: inline-block;"></div> PALM SPRINGS, CA 92262
19	Describe the specific damage or injury: THE CIRCUIT BOARD SHORTED OUT & THE GEARS WERE STRIPPED, FROM OUR "MIGHTY MULE FM350 GATE OPENER".
20	Explain the circumstances that led to the damage or injury: OUR NEIGHBORS HOUSE WAS ON FIRE & THE FIREMAN PUT IT OUT, THE FIREMAN WAS LOOKING FOR OUR NEIGHBORS THE FIREMAN GRABBED OUR GATE AND PULLED HARD TO OPEN IT, WHICH SHORTED OUT THE CIRCUIT BOARD AND STRIPPED THE GEARS (AND THE NEIGHBORS WERE NOT AT OUR HOUSE)
21	Explain why you believe the state is responsible for the damage or injury: THE DAMAGE WAS CAUSED BY FAE DAVID DELEON, EMPLOYED BY CAL FIRE/RCFD, ST. 24 AND WAS WITNESSED BY TODD HOPKINS, BATTALION CHIEF, BLYTHE BATTALION, CAL FIRE/RCFD.
22	Does the claim involve a state vehicle? <input type="radio"/> Yes <input checked="" type="radio"/> No If YES, provide the vehicle license number, if known:

Auto Insurance Information

23	Name of Insurance Carrier			
	Mailing Address	City	State	Zip
	Policy Number:	Tel:		
	Are you the registered owner of the vehicle?		<input type="radio"/> Yes	<input type="radio"/> No
	If NO, state name of owner:			
	Has a claim been filed with your insurance carrier, or will it be filed?		<input type="radio"/> Yes	<input type="radio"/> No
	Have you received any payment for this damage or injury?		<input type="radio"/> Yes	<input type="radio"/> No
	If yes, what amount did you receive?			
	Amount of deductible, if any:			
	Claimant's Drivers License Number:		Vehicle License Number:	
	Make of Vehicle:	Model:	Year:	
	Vehicle ID Number:			

Notice and Signature

24	I declare under penalty of perjury under the laws of the State of California that all the information I have provided is true and correct to the best of my information and belief. I further understand that if I have provided information that is false, intentionally incomplete, or misleading I may be charged with a felony punishable by up to four years in state prison and/or a fine of up to \$10,000 (Penal Code section 72).
	<div style="display: flex; justify-content: space-between; align-items: center;"> <div style="width: 40%;"> <div style="background-color: black; width: 150px; height: 1.2em; display: inline-block;"></div> <small>Signature of Claimant or Representative</small> </div> <div style="width: 55%; text-align: center;"> RONALD L. RICHARDS <small>Printed Name</small> </div> <div style="width: 45%; text-align: right;"> Date: 8-8-16 </div> </div>
25	Mail this form and all attachments with the \$25 filing fee or the "Filing Fee Waiver Request" to: Government Claims Program, P.O. Box 3035, Sacramento, CA, 95812-3035. Forms can also be delivered to the Victim Compensation and Government Claims Board, 400 R Street, 5th Floor, Sacramento 95811.